# EXHIBIT B

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opioids for minor and chronic pain conditions as a result of being duped by the opioid pharmaceutical industry.
Q. What percentage of doctors, in your view, were duped by the opioid pharmaceutical industry?
MR. ARBITBLIT: Objection. Vague.
BY MR. GISLESON:
Q. Take a step back.
Dr. Lembke, have you done anything to try and quantify the number of doctors who in your view were duped by the opioid pharmaceutical industry?
A. The research that I did for my book included qualitative interviews with multiple providers who had trained in different settings, across different years, who had different specialties, and the majority of them reported being duped by the opioid pharmaceutical industry.
Q. Is it your belief that a majority of doctors who were prescribing opioid medications were duped by the opioid pharmaceutical industry?
A. Yes, it is.
Q. Were any doctors in Lake County or Trumbull County, Ohio, duped into prescribing opioid medications?
A. Since the campaigns to mislead doctors were

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national campaigns, I have no reason to believe that the doctors in Lake and Trumbull County were an exception. So I think it's very likely that they too were duped into overprescribing.
Q. Now, in terms of the standards for prescribing opioid medications, we're obviously talking about doctors. Do the same standards apply to nurse practitioners, dentists, and physician assistants who had prescriptive privileges to opioid medications as applied to doctors?
MR. ARBITBLIT: Objection. Compound.
BY MR. GISLESON:
Q. Let me rephrase the question.
In terms of the prescription of opioid medications for pain, how did the standards that applied to doctors compare to the standards that applied to other prescribers of opioid medications?
A. Could you define "other prescribers"?
Q. Sure. Nurse practitioners, physician assistants, dentists, and anyone else who had a DEA license that permitted them to prescribe opioid medications.
MR. ARBITBLIT: Same objection.
THE WITNESS: The paradigm shift that occurred in opioid prescribing beginning late 1990s was

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a national paradigm shift. It shifted the culture in medicine across the board around opioid prescribing, and as such, I believe that anybody who prescribed opioids was affected by that paradigm shift.
BY MR. GISLESON:
Q. When you talk about a paradigm shift, do you mean that the medical standard of care for prescribing opioid medications changed?
MR. ARBITBLIT: Objection.
THE WITNESS: No, I wouldn't use that language.
BY MR. GISLESON:
Q. What do you mean by a paradigm shift?
A. I mean that it became commonly accepted for opioids to be first-line treatment for many different types of pain conditions, and that doctors were shamed through the use of terms like "opioid phobia" and quote, unquote, undertreatment of pain, into prescribing more opioids and they were also misled into believing that opioids are more effective than they actually are and less risky than they actually are.
In particular, they were told that as long as they were prescribing to a patient with a bona fide pain condition, it was very unlikely or very rare that that patient would become addicted to the opioid that

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they were prescribing.
Q. What do you mean by first-line treatment?
A. Opioids became the go-to remedy for all different types of pain.
Q. When you say it was commonly accepted for opioids to be the first-line treatment for many different types of pain conditions, does that mean that there was a national practice in terms of the circumstances under which prescription opioids medications could be prescribed for pain?
MR. ARBITBLIT: Object to form.
(Reporter clarification.)
BY MR. GISLESON:
Q. Sorry.
With a paradigm shift, what was the medical standard of care based on your research and analysis for prescribing opioid medications for pain?
MR. ARBITBLIT: Objection.
THE WITNESS: I'm not sure how you're defining the term "standard of care" or how you're using that term in this question.
BY MR. GISLESON:
Q. Under what circumstances, once this paradigm shift occurred, were doctors consistent, with their professional medical responsibilities, permitted to

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prescribe opioid medications for pain?
MR. ARBITBLIT: Objection.
THE WITNESS: Again, the way you frame the question in terms of "permitted to prescribe," I'm not quite sure what you're getting at or how best to answer that.
BY MR. GISLESON:
Q. Did doctors violate any professional codes applicable to the practice of medicine by prescribing opioid medications for pain?
MR. ARBITBLIT: Objection. Overbroad.
THE WITNESS: Could you be more specific about what codes you're referring to?
BY MR. GISLESON:
Q. Sure. Were there standards that applied to doctors once this paradigm shift changed for when opioid medications could be prescribed for pain?
MR. ARBITBLIT: Objection.
THE WITNESS: Yeah, what do you mean by "standards"?
BY MR. GISLESON:
Q. As a medical doctor, you don't know what a standard is when it comes to prescribing opioid medications for patients?
MR. ARBITBLIT: Object to form.

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Argumentative.
THE WITNESS: To me, that's a vague term that is not commonly used among doctors. We don't talk about standards.
BY MR. GISLESON:
Q. What word or phrase do you use to describe what the protocol or practice is for prescribing opioid medications for pain?
A. We talk about evidence-based medicine. We talk about guidelines. We talk about quality measures.
Q. Once this paradigm shift occurred, in your view, did doctors at that point have discretion to prescribe opioid medications as a first-line treatment for pain?
MR. ARBITBLIT: Objection. Overbroad.
THE WITNESS: Yeah, I'm not sure quite what you mean by "did they have discretion."
BY MR. GISLESON:
Q. Did the medical profession, once this paradigm shift occurred, make any effort to standardize the prescribing of opioid medications for pain?
MR. ARBITBLIT: Objection. Overbroad.
THE WITNESS: It wasn't so much a matter of standardizing. It was a matter of what the messages were around the benefits and harms of opioids as well

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as other incentives that would influence prescribing one way or another.
BY MR. GISLESON:
Q. Your view was that the paradigm shift in medicine toward liberal opioid prescribing has been a major factor contributing to the increased supply that fueled, in your view, the opioid epidemic; is that right?
A. Yes.
Q. When you say that the paradigm shift was a major factor contributing to the increased supply of opioid medications, what do you mean?
A. I mean that through false and misleading messages on the part of defendants, prescribers were misled into believing that opioids are more effective for the treatment of pain than they actually are, in particular chronic pain, and that the risks of prescribing, even at very high doses, even for very long duration, were minimal.
Doctors were also told that pain was undertreated, that it was essentially their fault because they were not prescribing enough opioids; they were opioid phobic. And doctors were furthermore educated that because the chances of their patients getting addicted to the opioids, they were prescribing

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was very low, that they essentially needn't pay much attention to that problem, and that if a patient presented looking as if they might be developing an addiction, they were actually pseudo-addicted and the proper response was to go up on the opioids.
Q. So the change in -- strike that.
This paradigm shift then resulted in a larger number of opioid medications being prescribed?
A. Yes.
Q. And in your view, were doctors acting in the belief that there was a legitimate medical purpose for prescribing opioids medications for pain?
MR. ARBITBLIT: Objection. Overbroad.
THE WITNESS: I do believe that the majority of doctors believed that they were prescribing for a legitimate medical purpose.
BY MR. GISLESON:
Q. When you say a majority, approximately how many?
A. I couldn't really put a number on it.
Q. Can you estimate it in any way?
MR. ARBITBLIT: Objection.
THE WITNESS: Not beyond saying majority.

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that to initially 30 patients and then later more than 100 patients in recognition of the fact that specific limits do have an impact on the public nuisance or the harm to the public health.
Q. So there should be a regulation that the plaintiffs can point to in this case that would identify what that specific volume is of prescriptions that is so high the prescriber's prescriptions can no longer have legitimate medical purpose?
MR. ARBITBLIT: Object to form.
THE WITNESS: Sorry, could you repeat the question to me? It was hard to understand. I wasn't sure how it linked to what I said previously.
BY MR. GISLESON:
Q. Based on your answer, there should be a regulation issued by the DEA someplace that identifies what the standard is for when a prescriber's volume of opioid prescriptions is so high that the prescriber can no longer have a legitimate medical purpose for issuing the prescriptions?
MR. ARBITBLIT: Objection. Argumentative. Misstates the record.
THE WITNESS: No, I didn't say that.
BY MR. GISLESON:
Q. Now, you mentioned a couple of times a

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"legitimate medical purpose." What, in your experience -- and we'll talk about since the paradigm shift -- was a legitimate medical purpose based on the pronouncements of the various medical organizations for issuing an opioid medical prescription for pain?
MR. ARBITBLIT: Objection. Vague.
BY MR. GISLESON:
Q. Do you know what a legitimate medical purpose is when it comes to prescribing opioid medications?
MR. ARBITBLIT: Objection. Vague.
THE WITNESS: I do have a section in my report where I talk about the legitimate use of opioids based on the evidence.
BY MR. GISLESON:
Q. I'm not talking about the evidence. I'm talking about the paradigm shift. Under the paradigm shift, what were legitimate medical purposes for prescribing opioid medications for pain?
MR. ARBITBLIT: Objection. Argumentative. Vague.
THE WITNESS: The way that opioids have been prescribed since the late 1990s have been, in many instances, not legitimate because they were not informed by science.

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BY MR. GISLESON:
Q. I understand that's your position, but the question is, for these different medical specialties who were issuing prescriptions for pain, what were the legitimate medical purposes that were recognized among those different specialties for issuing opioid prescriptions?
MR. ARBITBLIT: Objection. Vague. Argumentative. Asked and answered.
THE WITNESS: Yeah, I feel like I answered that question.
BY MR. GISLESON:
Q. But you didn't.
MR. ARBITBLIT: Argumentative. Not a question.
BY MR. GISLESON:
Q. You said before that you believe the majority of prescribers were issuing prescriptions because they believed that there was a legitimate medical purpose for the opioid prescription; is that right?
A. Yes.
Q. And from your research and analysis, what were the legitimate medical purposes that those prescribers were using in connection with issuing the prescriptions?

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MR. ARBITBLIT: Objection. Vague. Misstates the record. Do you want to rephrase it so that they believe they were legitimate, that would be different from trying to mislead the witness into saying they were legitimate without the belief.
MR. GISLESON: Please stop coaching the witness.
MR. ARBITBLIT: Please stop asking repetitive, argumentative questions.
BY MR. GISLESON:
Q. Dr. Lembke?
A. Yes.
Q. You said that in your view at least the majority of prescribers nationally were writing opioid prescriptions because they believed that those prescriptions had a legitimate medical purpose. What did you understand those legitimate medical purposes to be?
MR. ARBITBLIT: Objection. Argumentative.
THE WITNESS: As I said before, they believed that they were writing opioid prescriptions for a legitimate medical purpose because they were duped, when in fact, their prescribing was not legitimate because it was not informed by the science.

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Baristas"; is that correct?
A. Yes.
Q. And these are your views based on your education, training, and experience as a doctor who speaks publicly as well as researches extensively issues relating to the opioid epidemic; is that right?
MR. ARBITBLIT: Objection. Object to form.
THE WITNESS: I'm sorry. Could you restate the question?
BY MR. GISLESON:
Q. Sure. Are the views that you express in the first paragraph under "Doctors as Baristas" ones that are based on your education, training, experience, and research relating to the prescription of opioid medications?
A. Can you just give me a moment to read the paragraph?
Q. Actually, why don't you read it out loud, please?
MR. ARBITBLIT: Why don't you read the whole thing. She's got the right to read it before she starts reading out loud, Counsel. Take your time.
THE WITNESS: Would you like me to read it out loud now?

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BY MR. GISLESON:
Q. Please.
A. "The current prescription drug epidemic is not the result of the small population of deviant doctors willfully harming patients, although those doctors exist. Rather, it is the result of a large population of well-intended doctors working in healthcare factories that prioritize throughput of body parts on an assembly line over whole patient health. The result is overprescribing, which is faster and better reimbursed than educating or empathizing with patients.
"Pills that are addictive are particularly likely to be overprescribed because they provide patient customers with short-term satisfaction and a proxy for human attachment, but not necessarily improved health.
"When autonomy is truncated and professional status is linked to" --
(Reporter clarification.)
A. -- "earning power, in patient satisfaction surveys, doctors are vulnerable to objectifying patients as commodities rather than seeing them as people. Patients are vulnerable to utilizing doctors as nothing more than a source of drugs."
Q. You refer to the concept of the Toyotaization

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of medicine. Is that what you're describing here?
A. Yes, in part.
Q. Could you describe what you mean by the Toyotaization of medicine?
A. What I mean is that doctors -- the majority of doctors now work as salaried employees for large institutions and their practice is very heavily dictated by many pressures inside that institution, including pressures to see patients more quickly, pressures to have satisfied customers with rating surveys.
It is very common that a patient will have multiple doctors for multiple different healthcare problems, making it difficult to know, despite you know, electronic medical record, exactly what kind of care a patient is receiving from another provider or exactly what kind of medication they're being prescribed, which can result inadvertently in dangerous drug-drug combinations or overprescribing.
The bottom line is that in many ways, doctors have lost an enormous amount of autonomy. They're subject to Joint Commission quality measures, pain guidelines and other guidelines promulgated by professional medical societies and other different entities that essentially dictate how doctors practice

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and how they prescribe medications.
Q. Does that apply to how they prescribe opioid medications for pain?
A. Yes.
Q. Do you blame those institutions for creating that environment for doctors and other prescribers?
A. As I've stated in my book and in my report, there is lots of blame to go around, but the opioid pharmaceutical industry was really the key instigating factor for this paradigm shift.
Q. Move to strike. Nonresponsive. Doctor, I'm not trying to be rude.
You're talking about those institutions that were putting pressure on doctors to prescribe opioid medications. What were the institutions?
A. Well, the institutions included the opioid pharmaceutical industry that essentially both directly targeted doctors with an aggressive sales force and aggressive marketing campaign, but also targeted patients and targeted the various institutions that I mentioned inside of medicine that were promoting opioids.
Q. When you wrote that "the current prescription drug epidemic is not the result of a small population of deviant doctors willfully harming patients, although

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Strike that.
That does not involve any Walgreens employee speaking with a doctor to encourage that doctor to prescribe opioid medications, correct?
A. Well, Walgreens pharmacists speak with doctors on a daily basis, so what drug reps disseminate to pharmacists is very likely to be further disseminated to doctors.
Q. What factual basis do you have to say that a pharmacist for any of the chain pharmacy defendants in Ohio in fact communicated a manufacturer's message concerning opioid medications to a prescriber in Ohio?
MR. ARBITBLIT: Object to form.
THE WITNESS: On page 97 of my report, I talk about how Rite Aid pharmacy "collaborated with the American Pain Foundation, a patient advocacy organization funded largely by the pharmaceutical opioid industry to create a patient-facing educational pamphlet on pain to ensure customers receive the kind of information that will make a difference and" --
BY MR. GISLESON:
Q. That does not involve targeting doctors with an aggressive sales force, is it?
Doctor, the only aggressive sales force you can identify is the one that was the drug reps working

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for an opioid manufacturer, correct?
A. As I've stated before, the pharmacy defendants closely collaborated with the opioid manufacturers including the drug reps to propagate the same false and misleading messages.
Q. Move to strike as nonresponsive.
Doctor, the only aggressive sales force you can identify is the one where the drug reps were working for an opioid manufacturer, correct?
MR. ARBITBLIT: Object to form.
THE WITNESS: Again, I would argue that the pharmacies themselves became an aggressive sales force.
BY MR. GISLESON:
Q. You have no factual basis to say that any chain pharmacy defendant in fact made sales calls on prescribers in Ohio encouraging those prescribers to prescribe more opioid medications, correct?
A. I'm not aware of pharmacy defendant employees themselves going to doctors' offices, but in other ways by direct to patient promotion, and frankly, by promoting the false and misleading messages to their own pharmacists, they did propagate this misinformation.
Q. Move to strike the second part of the answer

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as nonresponsive.
Doctor, if you look at page 27 of your report, you have the heading "For Aggressive Sales Force"?
A. Yes, I do.
Q. You wrote, "As explained below, the pharmaceutical opioid industry retained an aggressive sales force incentivized to target doctors' offices and pharmacies to increase sales, thereby increasing the number of people exposed to opioids." Is that correct?
A. That's what I wrote there, yes.
Q. And by the reference to "incentivized to target pharmacies," that includes chain pharmacy defendants, correct?
A. Yes.
Q. In the next paragraph you wrote, "In 2012, the pharmaceutical industry spent $15 billion on face-to-face sales and promotional activity. These face-to-face promotional activities rely primarily on sales representatives and" --
A. I'm sorry, you cut out in the last little bit.
Q. After sales --
(Reporter clarification.)
Q. How about now? Can you hear me? Sometimes when I click on mute and then unmute, that helps.
If you look at the second paragraph that you

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wrote under "aggressive sales force," you wrote that "In 2012, the pharmaceutical industry spent $15 billion on face-to-face sales and promotional activity. These face-to-face promotional activities rely primarily on sales representatives," in parentheses you wrote drug reps, "who market their products directly to doctors' offices and pharmacies." Is that right?
A. Yes, that's what I wrote there.
Q. If you turn, please, to page 37, you made reference to key opinion leaders as being ones who were trying to drive this paradigm shift; is that right?
A. Yes.
Q. And the key opinion leaders were ones who were hired by the opioid manufacturers in your view, correct?
A. The key opinion leaders were also hired by the pharmaceutical defendants.
Q. Well, you wrote, "to encourage doctors to prescribe more opioids, opioid manufacturers promoted the careers of physicians who were sympathetic to their cause"; is that correct?
A. That's what I wrote there, yes, but on page 83 of my report I talk about, for example, Walgreens' Brody, a pharmacist, being promoted as a key opinion leader to create pharmacy superstores."

AFTERNOON SESSION
11:27 A.M. EDT 12:14 p.m. PDT
--o0o--
EXAMINATION RESUMED
BY MR. GISLESON:
Q. Dr. Lembke, have you ever practiced pharmacy?
A. If by that you mean am I a pharmacist, no.
Q. Did you ever attend pharmacy school?
A. No.
Q. Do you have a degree in pharmacy?
A. No.
Q. Have you ever trained as a pharmacy technician?
A. No.
Q. Have you ever worked in a pharmacy?
A. No.
Q. Have you ever dispensed opioid medications?
A. No.
Q. Have you taken any classes with pharmacists?
A. Not that I'm aware of.
Q. Have you ever trained pharmacists in the dispensing of opioid medications?
A. It's possible that in many talks I've given there were pharmacists in the audience.
Q. Have you ever trained pharmacists on the



dispensing of opioid medications?
A. Again, I've given many talks on the safety and efficacy of opioids and on the problem of increased supply and exposure as a major risk factor for addiction to opioids, and in those talks, some of which were CME talks and some of which were not, it's very possible that there were pharmacists in the audience.
Q. Have you ever given a talk to pharmacists in which you were advising the pharmacists specifically what steps they should follow before dispensing an opioid medication?
A. No.
Q. Have you ever worked for the Drug Enforcement Administration?
A. No.
Q. Have you ever worked for a state Board of Pharmacy?
A. No.
Q. Pharmacists are regulated by a state Board of Pharmacy; is that right?
A. Yes.
Q. The Board of Medicine does not regulate pharmacists; is that correct?
A. That's correct.
Q. Before writing the report that we've looked at



today, have you ever held yourself out as an expert in the practice of pharmacy?
A. I am an expert in the practice of detecting misuse, diversion, addiction. I do have expertise in the Controlled Substances Act and scheduled drugs, and I do have expertise in terms of my collaborative responsibility in relationship with pharmacists with whom I have multiple encounters on any given clinic day. I also have expertise in the prescription drug monitoring database which is a tool that pharmacists use.
Q. I'll ask again. Have you ever specifically held yourself out as an expert in the practice of pharmacy before you wrote this expert report?
MR. ARBITBLIT: Object to form.
THE WITNESS: Again, I do think I have expertise in terms of pharmacy practices, vis-a-vis the opioid epidemic, and I have held myself out as such.
BY MR. GISLESON:
Q. Have you ever given a talk in which you told the attendees that you were an expert in the practice of pharmacies by pharmacists?
A. No.
Q. Before issuing this report, had you ever evaluated whether a pharmacist complied with the duties



applicable to a pharmacist in dispensing an opioid medication pursuant to a prescription?
A. Yes.
Q. When?
A. As part of the research for my book, I interviewed multiple stakeholders and representatives within medicine, including pharmacists, and had discussions around their experiences with opioid misuse and diversion.
Q. Other than speaking with pharmacists, have you taken any classes on what a pharmacist should do before dispensing an opioid medication?
A. Well, pharmacists and doctors have similar responsibilities when it comes to detecting and allowing access to controlled substances, so in that sense, there is an overlapping education.
Q. Have you taken any classes that were specific to the steps that a pharmacist must take before dispensing an opioid medication?
MR. ARBITBLIT: Object to form.
THE WITNESS: My answer to that would be I've actually taught on the subject of what steps pharmacists should take before dispensing an opioid medication. It's part of my -- it's part of my broader expertise in addiction medicine.

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BY MR. GISLESON:
Q. And to whom did you teach that issue?
A. I've given multiple talks within Stanford and outside regarding how to use the prescription drug monitoring database, what constitutes red flags for opioid misuse and diversion. I have talked outside of Stanford, if I didn't say that already, on the same and I've also published articles on red flags for misuse and diversion of opioids. Beyond my book, that is.
Q. What training did pharmacists in Ohio receive in pharmacy school concerning their corresponding responsibility?
A. I assume that pharmacists in Ohio received the same training that pharmacists received nationally.
Q. Do you know for a fact what training they received on their corresponding responsibility while in pharmacy school?
A. I don't have specific knowledge about pharmacy schools in Ohio, but I have no evidence to suggest that it's any different from pharmacy training nationally.
Q. And what do you understand pharmacy training is nationally concerning a pharmacist's corresponding responsibility?
A. A pharmacist -- one of the pillars of drug utilization review is to detect for misuse and

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diversion of controlled substances. It's a major aspect of a pharmacist's job. They are taught to look out for red flags, and there is a long list of red flags that pharmacists are trained on.
Q. Do you know what courses pharmacists take in pharmacy school?
A. As I said, pharmacists are trained on detecting misuse and diversion, identifying red flags and doing what is in their corresponding responsibility as outlined by the Controlled Substances Act to prevent misuse and diversion.
Q. Did you do any research on the practice of pharmacy in connection with the report that you've given in this case?
A. Yes.
Q. What was the research?
A. I've reviewed a number of articles on the nature of a pharmacist's job, I've reviewed the regulations and the policies that the defendants put in place regarding the detection of red flags and a pharmacist's role in terms of misuse and diversion. I've researched lay press articles on whether or not pharmacists actually have the time and ability to do their due diligence around detecting and preventing red flags.

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Q. Anything else?
A. Can you repeat the question?
Q. What resource did you do on the practice of pharmacy in connection with the report that you've given in this case?
A. Can I review my report for a moment? I have looked at the medical literature on pharmacists and pharmacy dispensing. I have looked at DEA decisions on enforcement for pharmacies. I have looked at documents from the National Association of Chain Drugstores, and again, I have looked at the defendants' policies and procedures over time regarding red flags, PDMP, and dispensing.
Q. Where in your report does it identify the research that you did relating to the practice of pharmacy?
A. On page 103 at romanette 15, I discuss the research on the dangers of opioid and benzodiazapine prescribing and describe that as early as 2002 there were known risks combining opioids and benzodiazepines and that it is the responsibility of pharmacies to be aware of dangers of co-prescribing that are described in the medical literature and incorporate those into their practices. That literature is described on page 103, 104 of my report onto page 105, again, on

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page 107.
Q. That's research generally relating to co-prescribing. I'm asking what research generally you did on the practice of pharmacy by licensed pharmacists.
A. In addition to the many documents I reviewed provided by the defendants in discovery, I also cite a number of different articles in my report at different places regarding pharmacy practice. For example, on page -- for example, on page 124, I cite an article by Marilyn Bullock called, "The Evolution of the PDMP" in "Pharmacy Times." And she states, I quote, "mandating that all prescribers and pharmacists enroll in PDMPs and requiring more frequent data reports would create a more unified fight against drug diversion. Because pharmacists verify countless controlled substances every day, they can greatly affect drug diversion. Reviewing the PDMP prior to dispensing could become a part of the regular workflow regardless of a pharmacist's respected state mandates PDMP query and reporting. PDMP may not be the sole solution to the opioid crisis or other drug diversion, but they represent progress in combatting the epidemic."
Also, again, as stated before in multiple places in my report, I look at articles discussing the

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conditions in which pharmacists work, including specifically an article on page 151 from the University of Cincinnati. This article describes a study of Rite Aid pharmacy in which they report that Rite Aid pharmacists typically spent far less than 15 minutes on each prescription. In fact, according to a University of Cincinnati study of Rite Aid's prescription fill rates in 2011, Rite Aid pharmacists spent on average 3.22 minutes on any given prescription or 18.66 scripts per hour. This fill rate is a recipe for prescribing errors, providing inadequate time to investigate red flags or fulfill the corresponding responsibility to dispense controlled substances only for legitimate medical purposes.

Q. Can you identify any other articles you read in connection with your report that relate to the practice of pharmacy?

A. Yes, there are other articles in my report.

Q. How much time did you spend researching articles relating to the practice of pharmacy?

A. I don't have a specific number of hours.

Q. Can you estimate it in any way?

A. Many hours.

Q. And all the research that you described in your report on the practice of pharmacy is research

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that you performed after the plaintiffs' lawyers asked you to express an opinion about the chain pharmacy defendants; is that right?

A. The majority, yes.

Q. Have you published any peer-review articles that address the practice of pharmacy?

A. Well, I have published -- I have published articles on red flags, how to detect them, what constitutes a red flag in terms of opioid prescribing.

Q. Have you published any peer-review articles on any other subject?

A. I've published --

MR. ARBITBLIT: Object to form.

THE WITNESS: -- widely on the opioid epidemic which is pertain to pharmacy practice.

BY MR. GISLESON:

Q. Have you published any peer-reviewed articles specific to the practice of licensed pharmacists in dispensing opioid medications?

A. I do believe that much of my writing is relevant to the practice of pharmacy.

Q. I'm not asking about relevance. Have you published any peer-reviewed articles specific to the practice of licensed pharmacists in dispensing opioid medications?

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MR. ARBITBLIT: Object to form.

THE WITNESS: My publications are directed broadly to various stakeholders inside of medicine, and that would include pharmacists.

BY MR. GISLESON:

Q. Did you review any of the prescriptions in this case to determine whether they contained any red flags?

A. By that, do you mean the specific notes regarding specific prescriptions?

Q. The specific prescription itself.

A. No. Those are not --

Q. Have you reviewed any prescription data?

MR. ARBITBLIT: Object to form.

THE WITNESS: What do you mean by "prescription data"?

BY MR. GISLESON:

Q. Data that is maintained by one of the chain pharmacy defendants that identifies opioid medications that have been dispensed by that pharmacy defendant?

A. Yes.

Q. What data did you review?

A. So if you give me a moment to find it, please. Page 84 of my report contains a table with specific data on Walgreens' income due to the sale of OxyContin

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importantly showing that their annualized income in 2010 was roughly the same as their annualized income in 2017.

Q. Anything else -- strike that.

Any other pharmacy data relating to prescriptions for opioid medications that have been filled?

A. Again, on page 92, there is a table showing the average prescription size and number of OxyContin prescriptions written for Walgreens pharmacies.

Q. Can you tell from that data whether the prescriptions were issued for legitimate medical purpose?

MR. ARBITBLIT: Object to form.

THE WITNESS: Again, I'm reluctant to respond to your use of the term "legitimate medical purpose" because I don't think we're talking about that in the same way.

BY MR. GISLESON:

Q. Any other prescription data by one of the chain pharmacy defendants that you've reviewed?

A. Please give me a moment. And by "data," are you referring to numbers?

Q. Correct.

A. Uh-huh. On page 101, there was a survey

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performed by the National Association of Boards of Pharmacies showing that 83 percent of pharmacies surveyed believed that distractions due to performance metrics or measured wait times contributed to dispensing errors, and that 49 percent felt specific time measurements were a significant contributing factor which could reduce time for drug utilization review and ultimately result in unsafe prescribing.

Q. Did you ask plaintiffs' Counsel to give you access to any pharmacy defendant's data to show the specific number of Schedule 2 opioid medication prescriptions that that pharmacy filled?

MR. ARBITBLIT: I'll object and instruct not to answer with respect to discussions with Counsel.

BY MR. GISLESON:

Q. Did you request the opportunity to review any chain pharmacy defendants' prescription data to identify the average duration of any opioid prescription?

MR. ARBITBLIT: Same instruction.

MR. GISLESON: You instruct her not to answer?

MR. ARBITBLIT: Yes.

BY MR. GISLESON:

Q. Have you written any articles that

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specifically analyze a pharmacist's corresponding responsibility when dispensing an opioid medication?

A. No.

Q. Have you written any articles that specifically addresses the operation of a pharmacy as applied to prescription opioid medications?

A. I do address pharmacies in my book "Drug Dealer M.D.," although briefly.

Q. And what you say in your book on pharmacies there was that Internet pharmacies dispensed a very high percentage of controlled substances, correct?

A. Well, relative to their total prescribing, yes, but in terms of absolute numbers of prescriptions, those numbers are far higher for the brick-and-mortar pharmacies.

Q. And in terms of the percentage of controlled versus non-controlled substances, the brick-and-mortar pharmacies prescribe a much lower percentage of controlled related to non-controlled substances, correct?

A. I believe that is true.

Q. Have you written any articles about the pharmacy supply chain management?

A. I have published on that.

Q. What have you published?

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A. I believe in my book I do address -- well, I do address in my book the importance of access as a risk factor and the widespread availability across the country to opioids as a major risk factor for opioid addiction and overdose deaths. And I also have published in the --

(Reporter clarification.)

A. -- Journal of the American Medical Association an analysis of a Medicare 2013 database to look at opioid prescribing. I have two publications in JAMA on that topic using the Medicare database with the explicit emphasis in those articles of Medicare being a nationally representative sample demonstrating that these effects are widespread through every corner of the United States.

Q. Have you written any articles that address the process by which opioid medications specifically go from a manufacturer to a dispensing pharmacy?

A. I have not written on the nuts and bolts of that process, no.

Q. How many articles, approximately, have you published on the opioid crisis?

A. It would depend on whether we're talking about peer-reviewed articles or lay press articles.

Q. Both.

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A. I could get my CV out and count if you'd like.

Q. Greater than how many?

A. Why don't I get my CV out and count.

Q. Let me ask you this: So whatever articles you've written, are in your CV, right?

A. Yes. Actually, so for example, you proffered today a document that you stated that I wrote but I think that may, in fact, be the result of an oral interview which was then transcribed into written form. I'm not sure because I don't explicitly remember that document or that interview.

Q. In how many published articles, whether peer-reviewed or not prior to writing your expert report in this case have you attributed the opioid, in your words, epidemic to the chain pharmacy defendants?

A. So prior to me being retained in this case, I had written and taught and spoken publicly on the involvement of the opioid pharmaceutical industry without necessarily specifically calling out the pharmacies.

Q. Can you identify even a single article that you've written in which you call out the pharmacies as being the cause or one of the causes of the opioid epidemic?

A. Except for that brief mention in my book that

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Q. And how can we test whether time pressures in fact caused one of the pharmacists for a chain pharmacy to dispense an opioid medication that did not have a legitimate medical purpose?
MR. ARBITBLIT: Object to form.
THE WITNESS: Could you rephrase the question? I'm not really sure I understood.
BY MR. GISLESON:
Q. You claim that time pressures caused pharmacists in Lake and Trumbull County to dispense opioid medications that should not have been dispensed, right?
A. That's not the only factor, but yes, that's one the factors.
Q. How do we determine the extent to which that occurred?
MR. ARBITBLIT: Object to form.
BY MR. GISLESON:
Q. Stated differently, what did you do to determine whether time pressures, in fact, caused any of the pharmacists for the chain defendants to dispense an opioid medication that should not have been dispensed?
A. Again, I think that the trends that are documented to be occurring nationally at defendants'

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pharmacies would also have been occurring at the pharmacies in Lake and Trumbull County. I'd just refer you to page 102 of my report where I cite a number of different articles saying "pharmacy staffing levels can threaten patients' lives" in the journal drug topics. Also, pharmacists' workload contributes to errors in the "Science Daily." Those are footnotes 508 and 509.
Q. What did you do, though, to determine whether those findings, in fact, apply to the chain defendants' pharmacists in Lake and Trumbull Counties?
A. Again --
MR. ARBITBLIT: Object to form. Asked and answered.
THE WITNESS: I don't have any evidence to suggest that what was being practiced nationally according to pharmacy defendants' chain drugstore policies would not be equally applied to pharmacies in Lake or Trumbull County.
BY MR. GISLESON:
Q. Do you have any affirmative evidence for any prescriptions in Lake and Trumbull County that time pressures, in fact, caused prescriptions for opioid medications to be issued without a legitimate medical purpose?
MR. ARBITBLIT: Object to form. Asked

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and answered multiple times.
MR. GISLESON: She's not answering it.
MR. ARBITBLIT: That's your opinion.
BY MR. GISLESON:
Q. Please answer the question.
A. And I feel like I answered the question.
Q. Are you able to quantify in any way the number of pharmacists for chain pharmacy defendants who, in your view, experienced time pressure that caused them to fill an opioid medication prescription without a legitimate medical purpose?
A. Well, on page 102, the investigation of prescribing practices conducted by the "Chicago Tribune" in 2016 found that 49 percent of chain pharmacies committed fundamental errors in dispensing prescription of two medications --
(Reporter clarification.)
A. -- that were contraindicated for concurrent use due to risks of severe and potentially fatal adverse effects without warning customers of the danger. The investigators tested 255 pharmacies and found CVS, the nation's largest pharmacy retailer by store count, had the highest fill rate of any chain in the "Tribune" tests.
Q. Did any of that data apply to Lake or Trumbull

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Counties?
MR. ARBITBLIT: You're interrupting. It's habitual now. Stop interrupting her.
Finish your sentence, please, Doctor.
THE WITNESS: Dispensing the medications with no warning 63 percent of the time. Walgreens, one of CVS's main competitors had the lowest failure rate at 30 percent but that's still missing nearly one in three interactions. And also, Walmart pharmacies committed similar errors at a rate of 43 percent.
BY MR. GISLESON:
Q. What does a pharmacist do when performing a drug utilization review?
MR. ARBITBLIT: Objection. Vague. Overbroad.
You can answer if you have an answer.
THE WITNESS: I feel like I answered that before. Was there an aspect of my prior answer that left something wanting?
BY MR. GISLESON:
Q. Before this lawsuit, had you ever evaluated prescriptions that had been dispensed for opioid medications by a pharmacy to determine whether the pharmacist dispensed prescriptions without a legitimate medical purpose?

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A. Not in any systematic way, no.
Q. Can you identify any pharmacist working for one of the chain pharmacy defendants that dispensed opioid medications without a prescription?
MR. ARBITBLIT: Objection. Form.
THE WITNESS: There are multiple DEA enforcement actions cited in my report, and those enforcement actions do identify individual prescribers by name as well as pharmacists who dispensed --
BY MR. GISLESON:
Q. Can you identify any? Sorry.
A. Dispense.
Q. Go ahead.
A. Yeah, who dispensed opioids not in the context of a legitimate medical condition.
Q. Can you identify any pharmacists working in Lake or Trumbull Counties that dispensed opioid medications without a prescription?
MR. ARBITBLIT: Objection.
THE WITNESS: Again, I think that what was happening nationally was also happening in Lake and Trumbull County. I don't have any data to the contrary, but I can't identify a specific pharmacist by name in Lake or Trumbull County.

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BY MR. GISLESON:
Q. Did you speak with any pharmacists in Ohio?
A. No.
Q. Have you been to either Lake County or Trumbull County?
A. I don't -- I may have. I may have briefly.
Q. Do you know how many pharmacy stores Rite Aid has in Lake County?
A. I do not.
Q. Do you know how many pharmacists Rite Aid has in Lake County?
A. No.
Q. Do you know how many pharmacy stores Rite Aid has in Trumbull County?
A. No.
Q. Do you know how many pharmacists Rite Aid has in Trumbull County?
A. No.
Q. Do you know how many stores or pharmacists any of the chain pharmacy defendants have in either in Lake or Trumbull County?
A. No.
MR. GISLESON: Mr. Ladd, can you please get Tab 3? And Dr. Lembke, if you can go to Tab 3, please.

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(Exhibit 3 marked for identification.)
MR. LADD: Tab 3 has been marked as Lembke Exhibit 3.
BY MR. GISLESON:
Q. I'd like to show you what has been marked as Lembke Exhibit 3. Have you read Section 1306.04, Purpose of Issue of Prescription?
A. Yes, I have.
Q. Do you understand this is part of the Controlled Substances Act?
A. Yes, I do.
Q. This says, "A prescription for a controlled substance to be effective, must be issued for legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice."
What do you understand the phrase "legitimate medical purpose" to be in that paragraph?
A. An evidence-based purpose.
Q. What do you mean by "evidence-based purpose"?
A. There is evidence in the literature showing the potential benefits in the use of that medication for that condition outweigh the potential harms.
Q. Does the same standard for legitimate medical purpose apply to the prescriber as it does to the

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pharmacist dispensing the opioid medication?
MR. ARBITBLIT: I'm going to object, and interpose it calls for legal conclusion. Belated objection to the prior question on the same grounds.
BY MR. GISLESON:
Q. Do you have an understanding as to whether the reference to legitimate medical purpose has the same meaning for a prescriber as it does under the statute for a pharmacist?
MR. ARBITBLIT: Same objection.
THE WITNESS: I don't have an opinion on that.
BY MR. GISLESON:
Q. Do you know how to determine whether a prescription for an opioid medication has a legitimate medical purpose?
MR. ARBITBLIT: Objection. Vague. May or may not call for a legal conclusion depending on whether you're referring to the regulation.
BY MR. GISLESON:
Q. Do you have the technical ability, based on your training, education, and experience, to evaluate whether a prescription for an opioid medication has a legitimate medical purpose?
MR. ARBITBLIT: Same objection.

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A. So a pharmacist trying to exercise his or her good clinical judgment on whether or not to dispense, cannot do so unless they have availed themselves of all of the data at their disposal.

Now, a pharmacist is not going to have access to every piece of data in the known universe, but what they have access to, they need to check in order to make an informed clinical decision.

MR. ARBITBLIT: Counsel, we've been going for 75 minutes. That seems to be a reasonable time for a ten-minute break, if you're at a break point.

MR. GISLESON: Yeah, that's fine.

THE VIDEOGRAPHER: We are going off the record at 1:29.

(Recess taken 1:29 p.m. to 1:42 p.m.)

THE VIDEOGRAPHER: We are back on the record. The time is 1:42. Please proceed.

BY MR. GISLESON:

Q. How many years of school does a pharmacist have to complete in order to become a licensed pharmacist?

A. I don't know.

Q. What are the requirements for a pharmacist -- strike that.

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What are the requirements for a pharmacist to achieve a Doctorate of Pharmacy?

A. I assume it's additional training.

Q. Specifically, what must a pharmacist do to achieve a doctorate in pharmacy?

A. I don't know.

Q. Do pharmacists take any internships while they're in pharmacy school?

A. Probably.

Q. What?

A. I don't know the specific names.

Q. Do pharmacists receive any training in pharmacy school relevant to satisfying their corresponding responsibility?

A. Yes, I would assume so.

Q. Do you know for a fact whether pharmacists receive any training in pharmacy school on what they must do to satisfy their corresponding responsibility when it comes to dispensing opioid medications?

A. No.

Q. What information is on the licensing exam for pharmacists?

MR. ARBITBLIT: Object to form.

THE WITNESS: I have never looked at a licensing exam so I can't tell you at that specific level of detail.

BY MR. GISLESON:

Q. What continuing medical education requirements do pharmacists have in Ohio?

A. I don't know what their exact requirement numbers, but like all healthcare providers they have additional continuing education requirements.

Q. Did you do any investigation into what those continuing medical education requirements are in Ohio?

A. No.

Q. What's the difference between a pharmacist and a pharmacy technician?

A. Level of training.

Q. What is a pharmacy technician permitted to do?

A. I don't know exactly the difference in responsibilities.

Q. Can you identify any pharmacists for any of the chain pharmacy defendants who knowingly dispensed an opioid medication without a legitimate medical purpose?

A. Not by name, but my opinion is based on the aggregate.

Q. Go to page 76 in your report, please. In paragraph 6 you write, "Pharmacies leveraged their unique and pivotal position in the opioid supply chain

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to contribute to the unprecedented and unchecked flow of opioid pain pills into the community."

What do you mean by "unchecked flow of opioid pain pills into the community"?

A. By that I mean where pharmacy defendants had an opportunity to assess for misuse and diversion and opioids not dispensed for a legitimate medical condition for a legitimate physician-patient relationship, they did not take those opportunities to the extent that they should have as early as they should have, with as much due diligence as they should have. And instead, they did the opposite and incentivized the outflow of prescriptions, or as one of the pharmacy defendants, a manager stated their stores became a literal, quote, unquote, "funnel for opioid prescriptions getting out into the community."

Q. Is it your testimony that none of the pharmacists for the chain pharmacy defendants assessed opioid prescriptions for misuse and diversion?

MR. ARBITBLIT: Objection. Misstates.

THE WITNESS: That's not what I said.

BY MR. GISLESON:

Q. Do you agree that the pharmacists for the chain pharmacy defendants assessed whether misuse and diversion would occur with respect to particular opioid

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medication prescriptions?
MR. ARBITBLIT: Object to form.
THE WITNESS: The evidence in aggregate shows that pharmacists were disempowered and unable to exercise their clinical judgment because they neither had the time nor access to the necessary information to determine misuse and diversion when dispensing opioids. And furthermore, they were highly incentivized through bonuses, et cetera, to dispense more opioids. So where pharmacy defendants could have and should have put on the brakes, instead they pressed down on the accelerator.
BY MR. GISLESON:
Q. What work did you perform to determine whether pharmacists for the chain pharmacy defendants assessed whether misuse and diversion would occur with respect to particular opioid medication prescriptions in Lake and Trumbull County?
A. Well, I reviewed DEA evidence. I reviewed internal documents from defendants themselves. I reviewed the CSA. I reviewed the messages that went to pharmacists and directly to patient consumers and through that steppingstone to prescribers themselves. I reviewed the collaborations that pharmacy defendants had with distributors and manufacturers, which the

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documents themselves describe as, quote, unquote, "mutually beneficial arrangements."
All of those evidence in aggregate speak to a national and systemic policy among defendants' pharmacies for not doing their part to combat the opioid epidemic and contributing to the opioid epidemic including Lake and Trumbull Counties because I have not seen any evidence to suggest that by some miracle Lake and Trumbull Counties are different from the rest of the United States.
Q. What tests did you perform to determine whether any pharmacists for any of the chain pharmacy defendants were financially incentivized to fill opioid medication prescriptions without a legitimate medical purpose?
A. The financial incentive programs across defendants' pharmacies were national types of policies.
Q. Anything specific to the pharmacists in Lake and Trumbull Counties?
A. I don't have any reason to believe Lake and Trumbull Counties are an exception.
Q. Did you perform any tests of any kind or analyses to determine whether the pharmacists in Lake and Trumbull County for the chain pharmacy defendants, in fact, filled opioid prescriptions without a

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legitimate medical purpose because of incentive programs that were made available?
MR. ARBITBLIT: Objection. Vague.
THE WITNESS: My report is my analysis. The aggregate of all of the information in my report taken together, lead me to the opinion that pharmacists in Lake and Trumbull County were operating in the same conditions as pharmacists in defendants' pharmacies all over the United States.
BY MR. GISLESON:
Q. So in terms of your assessment of the chain defendants' pharmacists and pharmacies in Lake and Trumbull County, you are relying on evidence from outside of Lake and Trumbull County to draw your conclusions?
MR. ARBITBLIT: Objection. Misstates the record.
THE WITNESS: I'm relying on all kinds of different evidence, and I would just add that evidence demonstrating defendant pharmacies dispensing opioids in a way that put the public at-risk also puts Lake and Trumbull County at-risk because we know that these pills migrate from Florida all the way up the Blue Highway to Ohio.
In my report, there is a DEA enforcement

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showing that one of the prescribers who the DEA found negligent had patients who were filling prescriptions in Ohio, even though he himself resided in Florida, so these pills travel.
BY MR. GISLESON:
Q. When you say that there was an unchecked flow of opioid pain pills into Lake and Trumbull Counties, is it your testimony that the pharmacists for the chain defendants did not evaluate the individual prescriptions to determine whether they had a legitimate medical purpose?
MR. ARBITBLIT: Object to form. Misstates the record.
THE WITNESS: Again, my opinion and my testimony and what's in my report all speaks to the pharmacy defendants not having done enough early enough to really prevent the opioid epidemic. Although it was within their will and their power to do so, they chose to nibble at the edges, getting away with bear minimum instead of what they really could have done to prevent misuse and diversion.
BY MR. GISLESON:
Q. You said that doctors were duped. Do you believe pharmacists could have been duped as well about the safety and efficacy of opioids?

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BY MR. GISLESON
Q. Do you agree that it's wrong for an expert to be totally biased in a lawsuit?
A. That's just rude.
Q. Do you agree that it's wrong for an expert to be totally biased in a lawsuit?
MR. ARBITBLIT: Object to form.
THE WITNESS: If you're implying that I'm totally biased, I'm not.
BY MR. GISLESON:
Q. Do you agree that it's wrong for an expert to be totally biased in litigation?
A. I don't have an answer to that question. You know, you're obviously trying to imply something about me. I don't think that that question really warrants an answer.
Q. You said that "opioid manufacturers and distributors worked together with pharmacies to market specific opioids at the pharmacy counter."
What marketing occurred at the pharmacy counter in Lake and Trumbull Counties?
A. Pharmacists in the defendants' chains were the recipients of promotional messages that were very pro-opioid. I do talk in my report about the direct ADHERE program in which Butrans and Kadian were

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promoted at the pharmacy counter. Specifically Walmart and Giant Eagle partnered with McKesson around that.
Q. Did you identify any marketing that occurred at the pharmacy counter in Lake or Trumbull County by any of the pharmacy defendants?
A. Part of the marketing that occurred was the promotion of coupons for discounted opioids and the exchange of those coupons with embedded promotional material occurred at the pharmacy counter.
Q. Whose coupons?
A. Janssen, Nucynta, and Duragesic.
Q. So these were manufacture coupons, not a chain pharmacy defendant's coupon?
A. That's correct. Although the distributors and the pharmacies collaborated around those coupons. There was also advertising for specific opioid products in the pharmacies.
Q. What do you mean?
A. On page 71 of my report, a 2012 document titled "McKesson Manufacturing Marketing," talks about how, quote, "McKesson partners with pharmaceutical manufacturers such as Cephalon to define and actually customize strategies targeting key awareness, sales, and distribution goals at all stages of the product cycle."

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Q. So are you faulting, then, the chain pharmacy defendants for accepting from their customers a manufacturer's coupon that made opioid medication more affordable?
MR. ARBITBLIT: Object to form.
THE WITNESS: No. That is not what I said.
BY MR. GISLESON:
Q. Can you identify any chain pharmacy pharmacist in Lake or Trumbull County who dispensed an opioid medication without a legitimate medical purpose because the customer presented a coupon?
A. I do believe that somewhere in my report is evidence for these coupons being used in Ohio, probably including Lake and Trumbull County. On page 75 of my report, in 2013, McKesson promoted its pharmacy intervention program by letting Purdue know about their pharmacy brand kit.
(Reporter clarification.)
A. "The brand-specific pharmacy kit is mailed to each participating pharmacy prior to launch. This kit includes a cover letter and coaching guide. Purdue will have the opportunity to participate in the development and review of all pharmacy materials specific to their program. The brand kit can also

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include any additional resources that pharmacists should read as well as patient brochures to hand out during the coaching session. Purdue would develop and provide," unquote.
It goes on to page 76 and also prior to page 74, about how page 71 --
Q. Move to strike as nonresponsive.
A. Also on page 78, CVS CareMark courted opioid manufacturers by promising, quote, "identifying patients who may benefit from your product," unquote, and increasing, quote, "awareness of new treatments of therapies," unquote, including a pharmacy literature display to, quote, "educate patients via literature located adjacent to prescription counter."
Q. Move to strike --
A. The same --
Q. -- nonresponsive.
A. -- for 2011 document states, quote, "Communicate your products --
Q. Thank you. You've responded, Doctor.
A. Thank you.
Q. You're now just wasting time.
Are you able to design a study that could determine the extent to which individuals in Lake and Trumbull County developed an opioid use disorder as a

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result of taking an opioid medication under a doctor's care?
MR. ARBITBLIT: Object to form.
THE WITNESS: So again, I cite literature in my report that has conducted such studies looking at the risk of becoming addicted to opioids in patients with chronic pain who have become addicted specifically to the opioids their doctors are prescribing, and I detail that study in my report.
BY MR. GISLESON:
Q. Are there any studies specific to Lake and Trumbull Counties as to individuals who developed opioid use disorder as a result of taking prescription opioids pursuant to a doctor's prescription?
MR. ARBITBLIT: Object to form.
THE WITNESS: Again, there is no reason to believe that Lake and Trumbull County will be outliers in this case.
BY MR. GISLESON:
Q. Does the report in this case contain all of your opinions?
A. Based on the materials reviewed to date, yes.
Q. And does it identify all of the materials on which you relied in forming your opinions?
A. Yes.

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Q. Is all of the wording in the report yours?
A. Yes.
Q. Did you copy any of the material in your report from another source?
A. Not as far as I know, no. I mean, this is -- I have issued prior reports, and so there is --
Q. Which report which report did you update with this one?
A. I'm sorry. I don't understand your question.
Q. Did you update a prior report in creating this report?
A. My process of research has been ongoing over many years, and as I review more material, I assess it and I revise the report as I go along based on the information, the new information that I gather. Nothing that I have reviewed has changed my fundamental opinion.
Q. Did you start with a prior report that you supplemented to include allegations against the pharmacy defendants?
A. Yes.
Q. Which report?
A. The MDL report.
Q. For which track?
A. The original MDL report and then a subsequent

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West Virginia report.
MR. GISLESON: Don, I have more questions but to make sure that the other folks have a chance to ask their pharmacy-specific questions, I'm going to pass the witness for now. Is that all right?
MR. ARBITBLIT: Well, it's okay with me. I'm not saying that there is going to be time left when they're done.
MR. GISLESON: I realize that. So Kasper?
MR. STOFFELMAYR: I can ask a few questions. Doctor, are you okay to keep going or do you need a break?
THE WITNESS: I'm okay.
MR. STOFFELMAYR: Okay, thank you.
EXAMINATION
BY MR. STOFFELMAYR:
Q. Doctor, my name is Kasper Stoffelmayr, and I represent the Walgreens chain. I want to start with a couple of questions, not about pharmacies but about heroin addiction. That's also one of your areas of expertise, correct?
A. Yes.
Q. As I understand it, and please correct me if I'm misusing the terminology, there is a group, maybe a

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small group of heroin addicts who are sometimes called high-functioning addicts who can remain -- you know, have heroin use careers that can last many years or decades, correct?
A. Yes.
Q. And am I right that that is relatively unusual for somebody to be able to continue using heroin for decades without having something catastrophic happen?
A. I really couldn't answer that. There is not a lot of data or much written on that group. It's known to exist, but there is not a lot of information.
Q. Let me ask it this way: Among the people you treat or have encountered in your professional career, am I right that most heroin users will use heroin for a period of years and then will either successfully be able to stop using heroin to recover or unfortunately pass away, that it's unusual for someone to have used heroin for a decade by the time you see them?
A. I wouldn't say that's true. In my clinical experience, I have had patients who have used heroin for a very long time. The biggest problem with that population is not about the molecule itself because really it's fundamentally the same as a prescription opioid. The difference is how they can obtain it. And because heroin is illegal, they have to engage in

not receiving opioids for a legitimate medical purpose.
Q. Now, you just described that as a "large percentage." Are you able to put a specific number to it?
A. Again, I would say that the quadrupling between -- times four from the late 1990s to the peak, which is around 2011, 2012, would be the increased number that is not explained by legitimate medical condition.
Q. All right. I want to jump through to the bottom of the chart on page 3 and look at the same Column 43.1 for 2019.
Do you see that?
A. Yes.
Q. Is that 43.1 prescribing rate, does that represent evidence-based, legitimate medical prescriptions for opioids in Lake County?
MR. ARBITBLIT: Object to form.
THE WITNESS: So this table starts at 2006. It doesn't include information from the late 1990s up through 2006. And in general, what national trends show is that although prescribing -- opioid prescribing has decreased since its peak around 2012, it's still higher than the late 1990s levels, implying that a significant percentage of that 43.1 is, let's



say, legacy prescribing in addition to not prescribing for a legitimate medical condition. And I'm happy to explain that further if it would be helpful.
BY MR. CARTER:
Q. Compassionate prescribing to titrate users with dependence, that would be considered a legitimate prescribing practice from your perspective, correct?
A. Well, I wouldn't use the word "titrate," I would use the word taper. But yes, compassionate tapering would be a legitimate use.
Q. Now, I pulled out, for exemplar purposes, the 2006 data for Lake County, and the 2019 data for Lake County, if I asked you the same questions for Trumbull County would you provide the same answers in terms of reference to the testimony and the data?
A. Yes.
Q. And would you provide the same answer if I picked out any of those years in this chart on page 3 of Appendix 3?
MR. ARBITBLIT: Objection to form. Vague.
THE WITNESS: Yes.
BY MR. CARTER:
Q. All right. So putting the chart aside, in your expert opinion, what is the appropriate level of



evidence-based opioid prescribing that would be legitimate for Lake County for any year?
MR. ARBITBLIT: Object to form. Asked and answered.
THE WITNESS: Yes, I do feel I answered that. Is there something different or more that you would like from me?
BY MR. CARTER:
Q. I'm asking if you could put a prescribing rate per hundred or a percentage or a volume, a quantitative response to what you believe is an appropriate evidence-based, legitimate level of prescribing for Lake County.
A. I think legitimate, evidence-based prescribing has to include both quantitative and qualitative assessments. Quantitatively, as I've said before, per person I believe that we need to reduce prescribing back to the pre-1996 levels, and then qualitatively, it's important that opioid prescribing be evidence-based.
Q. Would you provide the same answer for Trumbull County?
A. Yes.
Q. And is that your best answer for both counties?



A. Yes.
Q. Thank you.
I want to ask you about pharmacies in Lake County that are not operated by one of the defendant chains in this case, so non-defendant pharmacies. Have you conducted any systematic analysis of the policies, practices related to dispensing of any non-defendant pharmacy in Lake County?
A. Again, my assessment is an aggregate looking at national chain policies. I have no reason to believe that pharmacies in Lake and Trumbull County are exempt from that, including pharmacies that are not named in this case.
Q. So can you identify for me any pharmacy that is not a defendant in this case for which you have analyzed, on a national level, their policies, procedures, training related to dispensing of opioid medications?
A. I have focused on the pharmacies that are named as defendants in this case.
Q. You say you've focused on them. Have you conducted a systematic analysis on a national basis of any pharmacy that is not Giant Eagle, Rite Aid, Walmart, Walgreens, or CVS?
A. No.

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Q. So pharmacist's exercise of professional judgment and skill is not limited to what is written in an official corporate policy, fair?
MR. ARBITBLIT: Object to form.
THE WITNESS: I think their ability to exercise their professional judgment is going to be very strongly influenced by what is in the POM and what they're incentivized to do.
BY MR. CARTER:
Q. My question was, is there exercise of professional judgment and skill limited to what is written in an official corporate policy?
MR. ARBITBLIT: Objection. Asked and answered.
THE WITNESS: I think I answered that.
BY MR. CARTER:
Q. Is it your testimony to the jury that if it's not in a corporate policy, a Walmart pharmacist or a Walgreens pharmacist or any other chain defendant pharmacist doesn't know what to do?
MR. ARBITBLIT: Objection. Misstates the testimony.
THE WITNESS: My testimony --
BY MR. CARTER:
Q. I want to be clear; I'm asking a separate

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question. Is it your testimony to the jury that if it's not in a corporate policy, the chain defendant pharmacists don't know what to do?
MR. ARBITBLIT: Object to form.
THE WITNESS: Again, I would say that the corporate chain policy has a huge impact on what pharmacies -- pharmacists will do. And there may be other sources of knowledge, but they will be less influential than the pharmacy chain policy, the management, and the various incentive plans that are in place.
BY MR. CARTER:
Q. Last question, on page 118 of your report, you quote, in romanette 27, an email that is quoted in a ProPublica story, and it's the last two words of romanette 27, a reference to driving sales. Do you see that?
A. Yes.
Q. Do you know that the individual who offered that email was deposed in this litigation?
A. No. I didn't know that.
Q. If the author of that email was testifying under oath about that email, would that be relevant information that you would want to consider in forming your opinion?

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A. I would certainly be happy to read the deposition or the testimony of that individual. It doesn't negate what is here, what was written and what was quoted.
Q. And you haven't conducted that review to this point, correct?
A. That's correct.
MR. CARTER: All right, I yield to Kyle.
EXAMINATION
BY MR. CRAWFORD:
Q. Dr. Lembke, my name is Kyle Crawford, and I'm Counsel for the CVS defendants.
On page 6 of your report you write, "Throughout my career I have interacted with pharmacies and pharmacists thousands of times."
Is that true today?
A. What do you mean? Is what true today?
Q. Is it true that you've interacted with thousands of pharmacies and pharmacists throughout your career?
A. Yes, I think that's true. I've interacted with -- I have a long career. I've interacted with many pharmacists and pharmacies.
Q. And did you interact with thousands of pharmacies and pharmacists before 2019?

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A. Yes. That's the cumulative interactions over a 25-plus-ear career.
Q. Would a prescription opioid epidemic have existed if Purdue did not market opioids?
A. That's hard to say. Certainly Purdue was a major player in creating the paradigm shift which led to increased prescribing, which led to the opioid epidemic. Whether or not other defendants -- I believe even in the absence of Purdue's role, it's possible and likely that the other defendants would have taken a similar role, but it's hard to say.
Q. Would a prescription opioid epidemic have existed had manufacturers did not market opioids?
A. I do think the marketing of opioids by opioid manufacturers was a major factor in the creation of the opioid epidemic. It's hard for me to say one way or the other if the distributors' culpability and the pharmacies' culpability independent of that would have created the opioid epidemic. I think everybody in the supply chain contributed to the opioid epidemic.
Q. Can you name any other company that contributed more to the opioid epidemic than Purdue?
A. In terms of opioid manufacturers, certainly Purdue was the major player, but I also think that the distributors and the pharmacies played a huge role.

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A. Well, again, I -- I haven't seen anything to refute that CVS engaged in these collaborations with opioid manufacturers to promote specific products at the counter.
Q. Dr. Lembke, what did the signs say in CVS stores that promoted opioids?
A. Again, on page 79, CVS promoted the opportunity to advertise specific direct-to-consumer advertising of specific products on --
Q. Move to strike.
My question is what did the sign say, not was there an opportunity for there to be signs, was there a possibility. If you don't know what the sign said, that's fine, and we can move on.
A. Yeah, I'm not sure what the sign said.
Q. Did CVS ever pay key opinion leaders?
A. Not that I'm finding.
Q. Did CVS ever pay medical schools to influence curriculum regarding the treatment of pain?
A. Not that I know of.
Q. Does CVS employ sales representatives who marketed prescription opioids to doctors?
A. CVS collaborated with opioid manufacturers, sales representatives, and other entities like Partners Against Pain and JCAHO, but as far as I know they did

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not employ their own drug reps.
Q. Have you reviewed the contents of any continuing education presented to CVS pharmacists?
Let me withdraw the question; ask it differently. Are you aware of any false statements contained in continuing education classes that CVS provided its pharmacists about prescription opioids?
A. Just give me a moment. Not that I'm able to identify right now.
Q. You mentioned earlier CVS's prescriber monitoring program. Do you recall that?
A. Can you tell me --
Q. Let me try and ask -- all right. You mentioned earlier a CVS prescriber monitoring program, and I'll represent to you that that's a program in which CVS decides whether to suspend pharmacies for filling the prescriptions of certain doctors. Do you recall that?
A. Yes.
Q. Is that kind of program required by law?
A. No.
Q. Would you agree that CVS's prescriber monitoring program was a helpful tool?
MR. ARBITBLIT: Object to form.
THE WITNESS: Are you specifically

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referring to the 2014 policy on page 128 of my report?
BY MR. CRAWFORD:
Q. I'm asking -- you're opining in your opinion that CVS failed to have effective controls against diversion, correct?
A. Yes.
Q. All right. And my question is, was CVS's prescriber monitoring program a helpful tool in -- let me -- let me rephrase.
Was the CVS prescriber monitoring program a helpful tool that contributed to CVS in fact having some effective controls against diversion?
A. Yes.
Q. And in your opinion you state that CVS could have implemented this program 15 years earlier, correct?
A. Yes.
Q. And what's the basis of your opinion that CVS could have implemented this program in the year 2000?
A. Because CVS would have had this data.
Q. Are you offering an opinion that it would have been technically feasible to create this program in the year 2000?
A. Maybe not the year 2000, but I believe it would have been technically feasible earlier than 2014.

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Q. You've never designed an algorithm to identify prescribers --
(Reporter clarification.)
A. I'm sorry. Could you say that again?
Q. Let me withdraw the question. Aside from CVSs prescriber monitoring program, has CVS done anything helpful to combat the opioid problem?
A. Yes, I do believe CVS has taken some measures to combat the opioid problem.
Q. What are those measures?
A. Over time, in an iterative process, CVS did change its policies and procedures regarding red flags in their investigation.
Q. Anything else?
A. I believe that CVS has also sponsored some drug take-back days. I believe CVS also may have participated in improving access to Naloxone.
Q. Anything else?
A. Not outside what's in my report.
Q. Are you aware that CVS uses data to analyze dispensing trends of its pharmacies?
A. Yes.
Q. And would that also be something that you would say was helpful for CVS to have done?
A. Yes.

three minutes.
THE VIDEOGRAPHER: Sounds like there is nothing further for the record?
MR. GISLESON: Can we go off the record and tell me how much time we have left?
THE VIDEOGRAPHER: She is correct, three minutes, but we can go off the record. Are we going off the record just for the moment or for the day?
MR. GISLESON: We can go back on the record.

EXAMINATION

BY MR. GISLESON:
Q. Dr. Lembke can you get your book, please, "Drug Dealer M.D." and turn to page 126.
A. Mr. Gisleson, I can't see you.
Q. You're better for it.
Can you turn to page 126, please. Under the heading, "Practicing with blinders on, not Toyota after all?" You wrote, "Good communication between doctors today is essentially to good care. Most patients have more than one doctor taking care of them, or they change doctors frequently due to insurance changes and other provisions of the managed care environment. Each doctor is busy prescribing the pills he or she believes will treat the patient while other doctors are



prescribing other pills. It is entirely commonplace to encounter a patient who is getting a stimulant from a psychiatrist --
(Reporter clarification.)
Q. You wrote, "Most patients have more than one doctor taking care of them, or they change doctors frequently due to insurance changes or other provisions of the managed care environment. Each doctor is busy prescribing the pills he or she believes will treat the patient while other doctors are prescribing other pills. It is entirely commonplace to encounter a patient who is getting a stimulant from a psychiatrist for attention deficit disorder, an opioid painkiller from a pain doctor for fibromyalgia, and a benzodiazapine from a primary care doctor for sleep."
That's consistent with your research and experience in terms of that being entirely commonplace, correct?
A. It being entirely commonplace does not make it right.
Q. And lastly, are you familiar with the Substance Abuse and Mental Health Services Administration?
A. Yes.
Q. Do you consider their published materials to



be the kind of materials on which professionals in the substance abuse field rely?
A. It would depend on the publication you were talking about.
Q. Do you agree with the statement, "PDMP data are best used in conjunction with other sources of information, including clinical assessment before making any determination about aberrant behavior because no validated and standardized criteria for the threshold of questionable activity have been established"?
MR. ARBITBLIT: Object to form.
THE WITNESS: I'd like to review that document.
MR. GISLESON: Why don't we go off the record.
MR. ARBITBLIT: We're not going off the record, Counsel, unless we're done. You've used your time.
MR. GISLESON: She wants to review the document.
Matt, can you show her, please, what was in Tab 8 and mark that as the next exhibit?
THE WITNESS: Is there more time or are we out of time?



MR. ARBITBLIT: We're out of time, but I'm going to allow this last question since you asked to review the document.
MR. LADD: Tab 8 is being marked as Lembke Exhibit 4.
(Exhibit 4 marked for identification.)
BY MR. GISLESON:
Q. You reviewed this SAMHSA In Brief?
A. I'm sorry, is this in the documents that were sent to me?
Q. Yes, I'm sorry, Tab 8.
A. Okay.
MR. SHERIDAN: While she's looking, may I request that the pending question be reread?
THE WITNESS: Yes, could you reread the question to that I know why I'm looking at this document?
BY MR. GISLESON:
Q. The first question was have you reviewed this SAMHSA In Brief?
A. Okay, and what came after that?
Q. And the next question is, which I asked you before, to give it context, if you go to the fourth page, the first full paragraph on the left-hand column says, "Behavior that suggests substance misuse, a